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Highlights from this issue

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Endoscopy plays a pivotal role in the diagnosis and treatment of Gastrointestinal disease. Gastrointestinal endoscopy (GIE) is widely performed with around 1.5 million procedures undertaken annually in the United Kingdom¹ and approximately 18.5 million procedures in the USA². The life-time chance of requiring a GIE is now greater than 35%.

As the technology of endoscopes and the technical expertise of endoscopists have advanced so have the number of clinical settings in which endoscopy may be applied. Modern endoscopists are now no longer simple diagnosticians who find pathology, take biopsies and refer on patients for others to manage. Endoscopists can now characterise and manage a wide range of conditions diagnosed at the time of an endoscopic procedure. In this issue of *Frontline Gastroenterology*, timed to coincide with ENDOLIVE UK, a number of articles describe the role of endoscopy in managing conditions throughout the GI tract.

The widespread adoption of cancer screening at population level and for individuals at increased risk has led to earlier diagnosis and the opportunity to treat cancer and pre cancer entirely endoscopically. Old *et al*³ describe the role of endoscopy in the management of Barrett's oesophagus. The authors describe how Barrett's can be diagnosed and characterised accurately with pre malignant and early malignant changes in the oesophagus treated to prevent progression to advanced cancer. With the increased ability to detect pathology comes the increased burden of surveillance. Oesophageal and colonic surveillance are reviewed³⁻⁵ with the clear message that measures to stratify risk are needed in order to deliver surveillance appropriately.

Cancer management was once the preserve of the surgeon but high quality assessment, decision making and skilled practice allow many lesions to be managed endoscopically avoiding the need for invasive surgery. Colorectal cancer screening has increased the diagnosis of 'polyp cancers' and the review by Neilson *et al*⁶ describes a practical approach to assessment and management of the potentially malignant polyp. Patel *et al*⁷ review recent developments in endoscopy technology explaining how this technology may assist diagnosis and management of luminal pathology.

The small bowel was once only imaged radiologically and managed by surgery but capsule endoscopy and small bowel enteroscopy mean that pathology maybe diagnosed and managed entirely medically.⁸ Fundamental to all endoscopy is the need to ensure that endoscopists delivering diagnostic and therapeutic endoscopy are well trained and deliver high quality procedures. Veitch⁹ describes how high quality endoscopy can be delivered and supported and Geraghty *et al*¹⁰ report on management of large polyps demonstrating that training and accreditation are crucial in order to maintain quality.

Demands on endoscopy services continue to grow as do the number of conditions that can be managed endoscopically. The opportunity to diagnose and treat more and more conditions present exciting times and an interesting if busy future for endoscopists. It is likely that moving into the middle of the 21st century endoscopists will focus on more narrow areas of practice treating a more limited range of conditions but with greater degrees of specialisation. It is important that as the range of therapeutic endoscopic techniques develops the role of these therapies is

clearly established with a strong evidence base to ensure they are delivered appropriately. On-going research to optimise use of resources and establish evidence based screening and surveillance programmes targeted at the most at risk patients is important. Establishing training, accreditation and on-going monitoring of quality in advanced endoscopic techniques is essential in order to ensure safe and optimal care of patients.

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