

Pourquoi l'endoscopie flexible est importante pour les chirurgiens digestifs et les chirurgiens généralistes ? Comment peut-on leur enseigner ?

Why Flexible Endoscopy is Important to General and Digestive Surgeons and how are we going to Teach it to Surgeons?

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Mots clés

- ◆ Endoscopie flexible thérapeutique
- ◆ Chirurgien digestif
- ◆ Chirurgien généraliste
- ◆ Enseignement de la chirurgie

Résumé

Introduction. L'endoscopie flexible interventionnelle supprime progressivement de nombreuses interventions chirurgicales. Cela conduit à une diminution du nombre et des types d'opérations effectuées par les chirurgiens. Alors que seule une poignée de procédures NOTES sont devenues pratique courante, cela a stimulé l'intérêt pour les interventions endoscopiques comme l'ESD, les procédures bariatriques, polypectomy hybride, la réparation de perforations et fistules, etc.

La formation, et l'accès, à l'endoscopie flexible pour les chirurgiens sont très variables d'un pays à l'autre. Dans les pays où les chirurgiens ont été formés en endoscopie, les critères de formation sont renforcés et les sociétés spécialisées parrainent des « Cours d'endoscopie flexible pour les chirurgiens ». En France, où les chirurgiens ne sont pas traditionnellement formés en endoscopie, la situation est plus difficile. Il y a peu de possibilités de formation pour les chirurgiens et aucune organisation pour former les internes ou boursiers en chirurgie et presque peu de filières établies pour accréditer les chirurgiens en endoscopie dans la plupart des hôpitaux.

Conclusion. Soit les chirurgiens apprennent l'endoscopie flexible, soit les opérations et les traitements des maladies relevant de la chirurgie tomberont de plus en plus dans le domaine des collègues d'endoscopie médicale. Avec des chirurgiens relégués à quelques procédures de base, et incapables de gérer les états pathologiques complexes, l'intérêt pour une carrière de chirurgien va continuer à baisser et le déficit en chirurgiens prenant soin de nos populations vieillissantes va s'accroître de façon alarmante. La France doit introduire l'endoscopie flexible dans le programme de base de formation en chirurgie, peut-être en utilisant le modèle de formation des États-Unis et aussi le « FES », examen de certification validé. Des cours postuniversitaires dans les applications de l'endoscopie flexible à la pratique chirurgicale doivent être organisés et les chirurgiens encouragés à y participer. Enfin, l'Académie de Chirurgie doit travailler avec les Sociétés d'endoscopie pour garantir les droits des chirurgiens pour qu'ils puissent être accrédités en endoscopie flexible et, qu'ils puissent accéder aux équipements et installations d'endoscopie dans les hôpitaux français.

Keywords

- ◆ Flexible therapeutic endoscopy
- ◆ Digestive surgeon
- ◆ General surgeon
- ◆ Surgical teaching

Abstract

Introduction. Interventional flexible endoscopy is progressively supplanting many surgical procedures. This leads to a decrease in the number and types of operations performed by surgeons. While only a handful of NOTES procedures have become common practice, it has stimulated interest in endoscopic interventions like ESD, endoluminal bariatric procedures, hybrid polypectomy, fistula and perforation repair, etc.

Training in and access to, flexible endoscopy for surgeons are highly variable from country to country. In countries where surgeons are trained in endoscopy, training criteria are being strengthened and specialty societies are sponsoring "flexible endoscopy for surgeons" courses. In France, where surgeons are not traditionally trained in endoscopy, the situation is more difficult. There are few training opportunities for surgeons and no procedure to train surgery residents or fellows and almost no pathway for privileging surgeons in endoscopy in most hospitals.

Conclusion. Surgeons will either learn flexible endoscopy or increasingly operations and surgical disease treatments will be relegated to our medical endoscopy colleagues. With surgeons relegated to a few basic procedures and incapable of managing complex disease states, the interest in a surgical career will continue to decline and projected deficits in surgeons to care for our aging population will accelerate alarmingly. France must introduce flexible endoscopy into the basic curriculum of surgery residency training, perhaps using the model of the US flexible endoscopy curriculum, and "FES" validated certifying exam. Post-graduate courses in applications of flexible endoscopy to surgical practice should be supported and surgeons encouraged to participate. Finally, the Académie Nationale de Chirurgie must work with the endoscopy societies to secure the rights of surgeons to become credentialed in flexible endoscopy and to access endoscopy equipment and suites in French hospitals.

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The introduction of video laparoscopy into general surgery in 1987, revolutionized the way surgery and was considered, perceived, taught, and subsequently "evolved". Most notably it gave rise to concepts like outpatient or "ambulatory" surgery, organ sparing surgery, surgical cosmesis, and cost effective treatment as measured by rapid return to normal activities. By the mid-1990's all abdominal and thoracic operations had been described in a "minimally invasive" format. A parallel development was occurring during the same timeframe in the field of flexible endoscopy. Driven by many of the same video-technologies and enabled by the same forces driving laparoscopic surgery (patient demand, decreased complications, cost effectiveness, marketability, etc), interventional flexible endoscopy has evolved into a formidable tool that effectively addresses many surgical diseases that formally only had the option of open, and sometimes laparoscopic, treatment options. Since, for the most part, endoscopic treatments are less invasive than traditional surgical options, it is not surprising that they are rapidly supplanting many operations (examples include: common duct exploration and bile duct repair, cancer staging, pancreatic pseudocysts and necrosis, early GI cancer treatments (ablations and resections), GI bleeding, etc). Combined with advances in interventional radiology, it is easy to see why, over the last 2 decades, the number and types of operations performed by surgeons have progressively decreased, and this decline in numbers is likely to continue.

Interestingly, the flexible endoscope, and each of the surgical procedures associated with it, was pioneered by surgeons (1). In the mid 1970's, medical gastroenterology began adopting many of these surgical procedures (polypectomy, ERCP, etc) and the practice of interventional endoscopy was developed. For the most part, surgeons paid little attention to this and readily ceded control of the endoscope to their medical colleagues (2). The end result, 35 years later, is that there is extreme variability from country to country in the amounts and types of flexible endoscopy performed by surgeons. In some countries (UK, Italy and the United States for example) surgeons are trained in flexible endoscopy during residency, while in others, France for example, surgeons are not trained and are essentially excluded from the use of endoscopy suites and the use of flexible endoscopes.

In 2005 the concept of natural orifice surgery was introduced. The proposal was essentially the performance of laparoscopic surgery using the flexible endoscope and a peroral, transvaginal or trans anal access. The concept excited surgeons and the medical device industry responded by developing dozens of new instruments and platforms to enable these complex procedures. While only a handful of true NOTES procedures have become common practice (POEM, Transrectal sigmoidectomy and in some places cholecystectomy), the interest of physicians and availability of new tools has stimulated international interest in endoscopic interventions like ESD, endoluminal bariatric procedures, hybrid polypectomy, fistula and perforation repair, etc.

The combination of surgical operations being replaced by endoscopic procedures and exciting technology developments in flexible endoscopy has led to a renewed interest on the part of surgeons to be trained in and have access to endoscopy. In countries where surgeons are already trained in endoscopy (US and Canada for example), residency training criteria are being strengthened and specialty societies are sponsoring training courses for "flexible endoscopy for surgeons" (3). In countries like France, where surgeons are not traditionally trained in endoscopy, the situation is more difficult. There are some training opportunities for surgeons starting to appear (http://www.eits.fr/courses/advanced/flex_endoscopy.php) but there exists no mechanism to train surgery residents or fellows. In all countries, this new interest in flexible endoscopy on the part of surgeons, is met with strong resistance on the part of the medical endoscopy com-

munity. In the United States, the major GI societies published a statement critical of surgical training in flex endo - this resulted in a class action law suit initiated by the American Board of Surgery (ABS) on the basis of "restraint of trade" and subsequent with the withdrawal of the statement by the GI societies. Recently the ABS mandated a 5 year endoscopy training *curriculum* for surgery residents that includes mandatory passing of the Fundamentals of Endoscopic Surgery (FES) high stakes exam before being certified as a surgeon (<http://www.absurgery.org/default.jsp?newsjointstate>).

Roadmap for France

It is apparent that the practice of contemporary surgery will be increasingly dependent on the technology of flexible endoscopy. Surgeons will either learn flexible endoscopy or increasingly operations and surgical disease treatments will be relegated to our medical endoscopy colleagues. With surgeons being increasingly relegated to a few basic procedures and incapable of managing complex disease states, it is inevitable that the current decline in interest in a career in surgery will increase and projected deficits in surgeons to care for our aging propulsions will accelerate alarmingly. It is clear that France must immediately introduce flexible endoscopy into the basic *curriculum* of surgery residency training. It would seem easiest to adopt with modifications the model of the US flex endo *curriculum*, perhaps including the validated certifying exam "FES". Post graduate courses in specific applications of flexible endoscopy to surgical practice should be supported and surgeons encouraged to participate.

Finally, the Académie nationale de Chirurgie must work with the endoscopy societies to secure the rights of surgeons to become credentialed in flexible endoscopy and to access endoscopy equipment and suites in French hospitals.

Conclusion

Flexible endoscopy is rapidly evolving into an important minimally invasive tool. It seems apparent that for surgeons to remain relevant and useful to the public they need to embrace flexible endoscopy and begin to integrate it into their training and practices. The French Académie nationale de Chirurgie has a difficult and critical role in negotiating the reversal of the exclusion of French surgeons from the practice of flexible endoscopy.

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