

Preface

As 2016 dawns, Interventional Pulmonology has become an essential component of pulmonary medicine, as vital and as widely accepted as Interventional Cardiology. This subspecialty is extremely attractive to most pulmonologists, and the establishment of national and international organizations, myriad scholarly contributions to the literature, and well-attended scientific seminars provide definitive evidence of its worldwide favor. One possible reason for this widespread interest is that endobronchial procedures often yield important results and positively impact patients' well-being. For example, a successful lung transplantation cannot be achieved without the contributions of a bronchoscopist. Similarly, there is no doubt about the contributions bronchoscope has made in the diagnosis and staging of lung cancer. In fact, there are only a handful of pulmonary ailments that a bronchoscope cannot diagnose, palliate, or cure.

Interventional pulmonary medicine thrives within the penumbra of multiple specialties: Bronchoscopists provide the transitional step from the unknown to the known, from lesion to cancer, from wheezes to granulomatosis with polyangiitis, and from treatment to palliation. Interventional pulmonologists are uniquely positioned to improve many fields because bronchoscopy offers the best access to lung tissue.

The modern day interventional pulmonologist has a dual commitment: to be a competent endoscopist and to demonstrate a thorough knowledge of diseases involving the central airways, as well as other systemic diseases that can affect the central airways. This body of knowledge must also include the understanding of symptoms that are not associated with airways disease.

The objective of this monograph is to illuminate the fact that Interventional Pulmonology offers more than mere interventions. The bronchoscopist should be able to recognize aspiration in the absence of a foreign body and perhaps diagnose inflammatory bowel disease before it involves the gastrointestinal tract. The interventional pulmonologist should be able to differentiate when a cardiac or pulmonary embolism evaluation should be considered, rather than a bronchoscopy. One must consider the patient as an individual, not an endobronchial tree. With

appropriate training, anyone can perform a procedure, but the editors strongly believe that “a good bronchoscopist is the one who knows when not to perform the procedure.”

The optimal application of bronchoscopy arises from the coalescence of medical science and prudence, and the editors vehemently assert that reducing the cost of health care is a civic responsibility. However, the current directives of Interventional Pulmonology, to a significant degree, are based upon expert opinion, not evidence. In addition, the cost-effectiveness of new elective bronchoscopy procedures has not been well documented. Therefore, the interventionalist must rise above his or her technical abilities and consider noninvasive therapeutic options, then perform an unnecessary procedure. The bronchoscopist should be a technology savant, not a technology servant.

We, the editors, have made a sincere effort to focus only on the conditions that require limited or no technical interventions within the purview of Interventional Pulmonology. Although we do not claim this book encompasses the subject in its entirety, we offer our attempt to illuminate the noninterventional aspects of our subspecialty. We applaud all the authors for their support and timely contributions to this project; the credit is theirs to claim. Our ultimate objective is the well-being of patients suffering with central airways diseases, through the safe and cost-effective practice of Interventional Pulmonology.

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