

A Questionnaire Study on Bronchoscopy: Today's Informations Are the Common Sense of Tomorrow

Dear Editor,

Bronchoscopy is a basic diagnostic and therapeutic device that allows scanning of the trachea, main bronchi, and segmental bronchus directly and has been used for over 110 years—first in internal medicine and then routinely by pulmonologists and thoracic surgery specialists, as well as by anesthesiologists, if required. The use of flexible fiberoptic bronchoscopy (fiberoptic bronchoscopy or video bronchoscopy) in the last 40 years is an indisputable revolutionary development of this method.

It is quite natural that there are differences in the application of a medical method that forms a key feature as it is and is used by many experts. Overall, despite having the same function, the different usage of bronchoscopy is sometimes the subject of scientific and professional debates. Since medicine is becoming less invasive, with the tendency of using methods that have less physical, financial, and emotional impact on the patient, the issue of how the most current use of bronchoscopy should be applied is being discussed more often.

Here, in this direction, the survey conducted by Tozkoparan et al. (1) on pulmonologists and thoracic surgeons offers interesting findings that should be considered.

In the study, which analyzed the responses of a total of 146 physicians (93 pulmonologists, 30 thoracic surgeons, and 23 anesthesiologists), it was observed that different aspects of the documentation on fiberoptic bronchoscopy (FOB) were analyzed. The number of physician respondents, although it is limited when the number of specialists in our country is considered, gives important insight into the issue. Furthermore, due to the design of the survey, it was not possible to know whether the respondent physicians represented the experts working in university hospitals, training and research hospitals, public hospitals, and private hospitals in our country.

When the answers are analyzed, it is understood that before the procedure, thoracic surgeons, probably due to the sensitivity of the surgical procedure, would like to see additional biochemical parameters (57%) associated with hemorrhage.

Interestingly, the survey shows that before FOB, unlike other expert groups, anesthesiologists do not need to see a tomography. This situation probably stems from the fact that anesthesiologists use FOB in the OR and intensive care units for emergency pathology or secretion retention.

Furthermore, the reason for pulmonologists' using a higher proportion of local anesthesia before the procedure might be that unlike anesthesiologists and thoracic surgery specialists, they usually work on awake patients.

The study also shows that anesthesiologists use propofol more often, whereas thoracic surgeons use sedation less compared to other physicians. Propofol is basically an intravenous anesthetic agent that requires certain knowledge and experience, especially because of its application, with dose confidence intervals and pharmacological features, and, on the other hand, is frequently used by anesthesiologists. Therefore, this finding is not surprising.

Whether bronchoscopy should be applied through the nose or mouth is a technical issue that has not been agreed on yet. The authors also state that pulmonologists usually prefer applying the process in the supine position through the nose. However, it is a fact that some chest disease hospitals use oral application more frequently. One might think that generally, professional and academic traditions of training and research hospitals play a role in this regard.

Because of the growing acceptance of endobronchial ultrasound and transbronchial aspiration performed in this way, especially in recent years, the number of interventional procedures that are performed with fiberoptic bronchoscopy is increasing. However, according to the results of the survey conducted by the researchers, it is observed that there is a significant difference on this subject among the physicians.

In fact, it is required that one describes acceptable morbidity and mortality rates, interventional procedures performed with bronchoscopy, and how to perform bronchoscopy training sufficiently and in detail in the syllabus of thoracic surgery training, anesthesiology training, and, especially, in chest disease residency training. Although this issue is covered in certain detail in the chest disease syllabus in our country, this survey has made it clear that the technical and professional elements of this subject display substantial differences. But, still, the certain indisputable indications of rigid bronchoscopy, such as endobronchial treatment, bronchial stenosis, stent, and massive hemoptysis management, are important issues that have almost never been discussed by the researchers.

In addition, the applications recently performed with FOB that are expected to be used more frequently in the future, such as navigation bronchoscopy, optical interference bronchoscopy, and confocal interference, were never mentioned in the study.

Most importantly, it is a fact that further studies are necessary in order to apply, teach, and develop bronchoscopy in accordance with international standards. I congratulate the researchers for this valuable, informative, and targeting study, and I invite all pulmonologists and thoracic surgeons to conduct studies in order to find answers to the new questions that have arisen here.

Akif Turna

Department of Thoracic Surgery, İstanbul University Cerrahpaşa Faculty of Medicine, İstanbul

Address for correspondence: Akif Turna, Department of Thoracic Surgery, İstanbul University Cerrahpaşa Faculty of Medicine, İstanbul, Turkey

E-mail: aturna@istanbul.edu.tr

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