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Safety and Fibreoptic Bronchoscopy

SIR,—Though it is some weeks since I read your leading article on the possible dangers of fibreoptic bronchoscopy (31 August, p. 542) I have been reflecting ever since on a different type of hazard which may be more important than any of those you mentioned. I refer to the consequences of the dangerous assumption that bronchoscopists who are unable to use the "conventional" or "rigid" instrument, and who therefore have to rely on the fibreoptic instrument, are capable of performing under all circumstances an adequate bronchoscopic examination and all the manoeuvres which such an examination may involve. The fibreoptic bronchoscope has only two real advantages: (1) it can enable the operator to inspect the sub-segmental divisions of the upper lobe bronchi, which may not be possible with optical telescopes of the conventional type, and (2) it can be passed into the peripheral bronchi of the middle and lower lobes and the lingular segment of the left upper lobe. Tumours can therefore be visualized in these normally inaccessible situations, and tissue taken for biopsy either with forceps or by the bronchial brushing technique. In these circumstances the fibreoptic bronchoscope is a valuable adjunct to examination with the conventional type of instrument, but the claim actively promoted by the manufacturers that it can be directed into fourth or higher generation bronchi to reach the site of a small peripheral bronchial carcinoma is, in the vast majority of cases, foolishly optimistic.

It is, of course, not difficult to visualize a bronchial carcinoma with a fibreoptic bronchoscope in lobar, segmental, or sub-segmental bronchi provided bronchial secretions are scanty and there is no bleeding, but even in these circumstances it is not easy

to obtain an adequate biopsy with the tiny forceps provided, especially if the surface of the tumour is necrotic or if the forceps have to cut through intact mucosa to reach tumour tissue. When, as so often happens, there is even a moderate amount of mucus or pus in the bronchi or if mucosal bleeding occurs the fibreoptic instrument is virtually useless, because its small lens quickly becomes obscured and the facilities for suction, particularly when the tip of the bronchoscope is sharply angulated, often make it difficult to maintain a clear field of vision while a specimen for biopsy is being taken.

There have recently been great advances in the design of conventional bronchoscopic equipment as a result of which it is now greatly superior to fibreoptic equipment for inspection and biopsy of tumours in all lobar and segmental bronchi. Hopkin's telescopes (straight, right angle, and oblique) provide much better optical definition than can be obtained with fibreoptic systems, and forceps of ingenious design permit large specimens for biopsy to be taken under telescopic vision from all segmental bronchi, including the apical segmental bronchi of the upper lobes. Conventional bronchoscopic equipment can also be used for the removal of intrabronchial foreign bodies, which is, of course, completely impossible with fibre-optic instruments.

There is a widespread belief that fibre-optic bronchoscopy under local anaesthesia is an undisturbing procedure for the patient. This is by no means always the case. Local anaesthesia of the larynx, trachea, and bronchi is, at best, imperfect and unpredictable and there are few patients who do not experience some discomfort when even a fibreoptic bronchoscope is being manipulated

in their air passages. Modern conventional bronchoscopes are now all designed for oxygen injection ventilation, which has eliminated virtually all danger from bronchoscopic examination under general anaesthesia, and there can no longer be any justification for continuing the barbarous practice of performing these investigations, whatever instrument is used, under local anaesthesia.

Bronchoscopy is a vitally important diagnostic procedure which should be carried out only by physicians and surgeons who are fully trained in the use of both conventional and fibreoptic instruments. It is not an investigation which can safely be left to the enthusiastic amateur equipped only with a fibreoptic bronchoscope. From the economic point of view also there is a strong case for restricting the supply of these bronchoscopes, which cost £3,500 each and are expensive to maintain, to centres where full facilities already exist for conventional bronchoscopy.—I am, etc.,

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Endoscopy Service for Dyspepsia

SIR,—Dr. R. J. Barnes and his colleagues (26 October, p. 214) have certainly proved the advantage of having an endoscopy service to supplement radiological investigation of dyspepsia in general practice. However, few details are given of their clinical assessment. This, as I am sure they will agree, is essential, for hiatus hernia and gall stones can be an incidental symptomless finding.

They sensibly classify mucosal abnormalities under normal findings. I fear that not every present-day endoscopist would be so